BON SECOURS MERCY HEALTH

Community Health Annual Report

2021

Contents

Annual report project manager: Brooke Lynch

Working daily to live our mission of extending the compassionate ministry of Jesus, our community health efforts continuously strive to improve the health and well-being of our communities by bringing good help to those in need, especially people who are poor, dying and underserved.

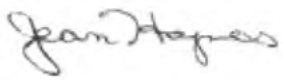
Many individuals and communities experienced hardship in 2021, some of which were exacerbated by the COVID-19 pandemic, others a continuation of systemic disparities that have contributed to negative health outcomes for generations. Regardless of the source of these challenges, Bon Secours Mercy Health (BSMH) remains committed to collaboratively supporting innovative and sustainable projects, programs and partnerships that leverage both social and financial capital to address some of the greatest health and social needs experienced by our patients, communities and local neighbors.

It is with a continued spirit of human dignity, integrity, compassion, stewardship and service that we share our 2021 Community Health Annual Report. Looking back on an unprecedented year, we celebrate the partnerships, community leaders and advocates that have informed and guided the work of our Ministry. We contemplate how to improve health outcomes for those in need. We strive to provide quality care for those we serve. We aim to create diverse and welcoming environments within our hospitals and within our communities and we also extend an invitation for new partners, new ideas and new opportunities that will continue to drive our work for 2022.

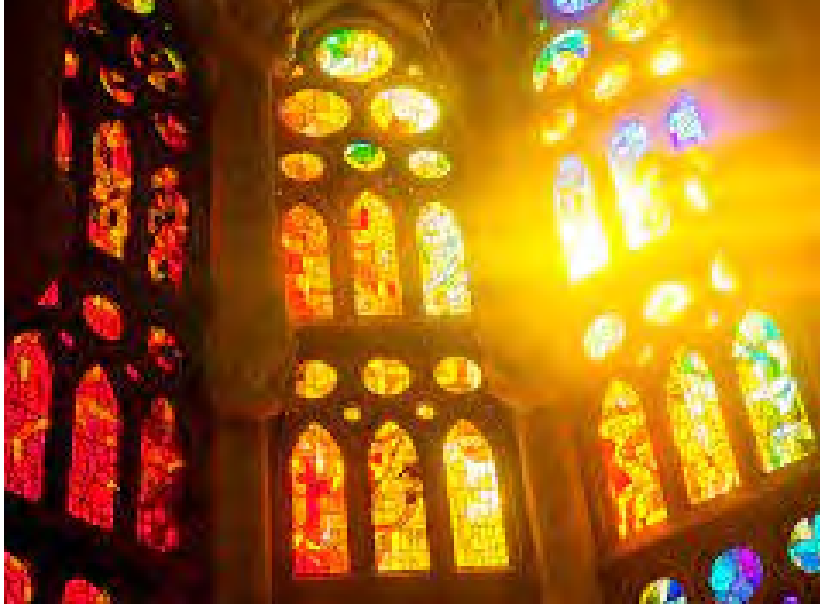
On behalf of Bon Secours Mercy Health, thank you for being a valued partner.

In Good Health,

Wael Haidar, MD
Chief Clinical Officer
Bon Secours Mercy Health



Jean Haynes
Chief Population Health Officer
Bon Secours Mercy Health



Our Mission, Vision and Values

MISSION

Our mission is to extend the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

VISION

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

VALUES

Human Dignity
We commit to upholding the sacredness of life and being respectful and inclusive of everyone.

Integrity
We commit to acting ethically and modeling right relationships in all of our individual and organizational encounters.

Compassion
We commit to accompanying those we serve with mercy and tenderness, recognizing that "being with" is as important as "doing for."

Stewardship
We commit to promoting the responsible use of all human and financial resources, including Earth itself.

Service
We commit to providing the highest quality in every dimension of our ministry.

Community Health

Community Health addresses the social dynamics and underlying factors that impact the health and well-being of the individuals and communities we serve in order to promote justice and health equity. We do this by collaborating with internal and external partners and utilizing diverse resources and assets.

Community Health framework

The Community Health framework supports five core work streams that allow our team to see health broadly through a lens of equity, addressing the root causes of health disparity through intentional engagement, comprehensive community investment and impactful program delivery.

- **Community health needs assessment** led locally by community health directors
- Addressing the **social determinants of health** and social needs for patients and communities we serve
- **Asset-based community investment** to improve infrastructure and develop upstream interventions in all markets
- **Community benefit** reporting demonstrates the ministry's commitment to community service, documenting investments we make in our communities and maintaining our non-profit status
- Building local, regional and national **partnerships** to support community based work

Community Health Needs Assessment (CHNA) & Community Health Implementation Plan (CHIP)

The work of the Community Health Needs Assessment (CHNA) demonstrates how Bon Secours Mercy Health hospitals work with community and public health partners to assess specific community health needs and develop effective strategies for improving health in our communities. Each BSMH market devotes significant time and attention to researching and planning ways to address the community's most urgent needs. One element of this process is a comprehensive CHNA for each facility, which is conducted every three years.

Through our focused assessments, local residents and stakeholders identify the greatest health needs in each of our communities, enabling local teams to direct resources toward outreach, prevention, education, and wellness opportunities that can make the greatest health impact.

Function and purpose of local CHNAs and CHIPs:

- Inform organizational and market strategies
- Improve and create collaborative community partnerships that promote a broad lens of health and well-being
- Prioritize community and stakeholder vision in health planning and local investment
- Create intentional community engagement and feedback opportunities for community residents and stakeholders, BSMH associates, and community-based organizations
- Prioritize greatest health, well-being and social determinant local needs, and create a formal plan to address these needs
- Provide a central tool for advancing health equity, investing in local communities, and incorporating the voice of community residents in health planning and resource allocation
- Create new opportunities to engage community residents, stakeholders and organizations

CHNAs and CHIPs for all Bon Secours and Mercy Health facilities were completed in 2019 and continue to be implemented in 2021. Community members and stakeholders are encouraged to download and review documents online for **Bon Secours and Mercy Health.**

The next CHNA process will be completed December 31, 2022

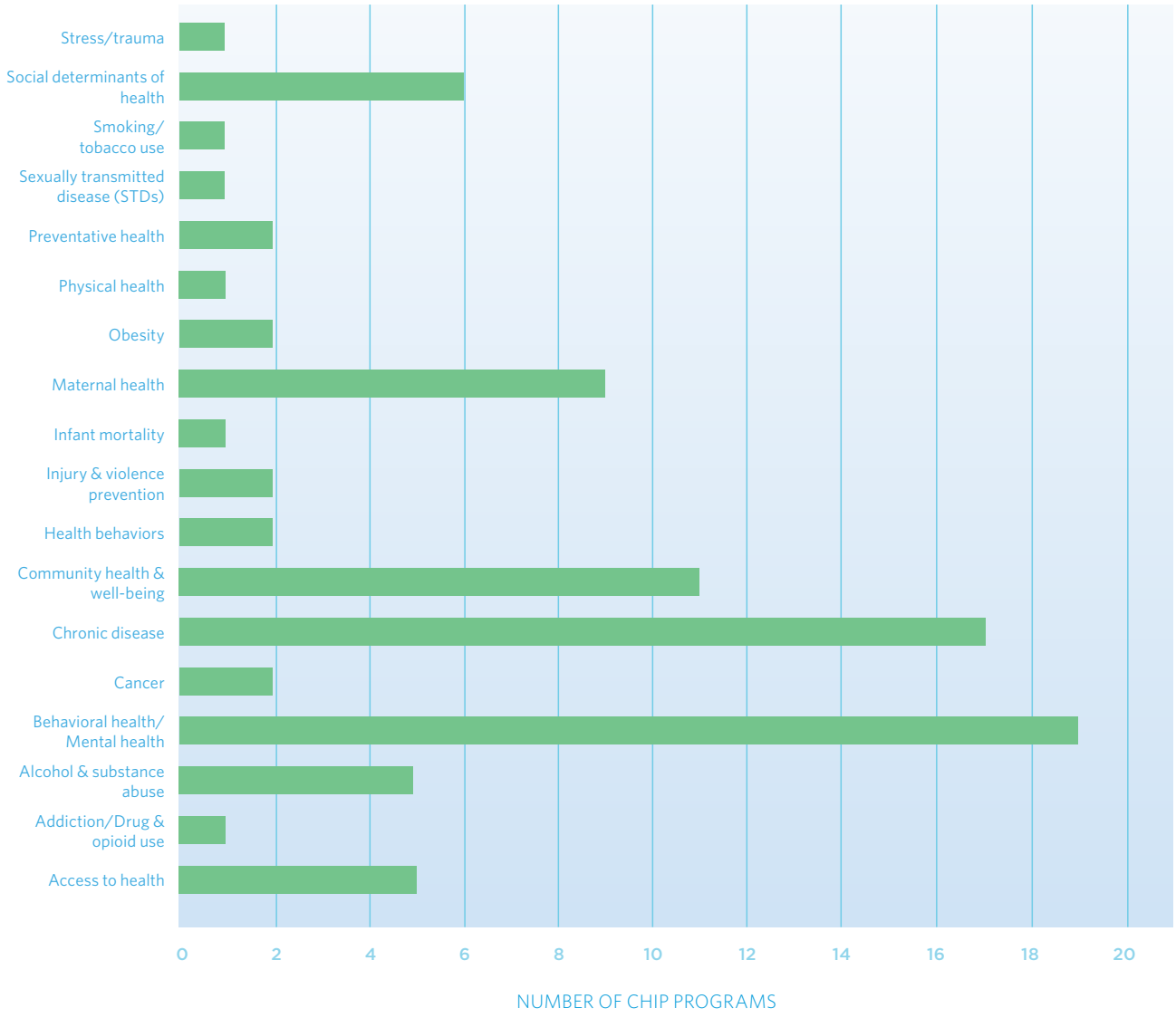
- Updated list of community-defined, prioritized health needs
- Increased commitment to address social determinants of health

PROGRAM OUTCOME HIGHLIGHTS

8 markets have implemented programs, trained additional staff, increased patient encounters or invested in community partnerships to **address behavioral health needs.**

9 markets have initiated community partnerships, conducted additional screenings, engaged community partners and increased access to care to **address chronic disease.**

2019 CHNA PRIORITIES & ASSOCIATED CHIP PROGRAMS — ALL MARKETS



Social Determinants of Health & Social Needs

Community Health is committed to addressing the social determinants of health and social needs for patients and communities throughout our footprint. With a deep understanding of both areas, the team is working systematically across the ministry and in our local communities to ensure we respond holistically and impactfully.

Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH) — According to the World Health Organization, SDOH refer to the conditions in which people are born, grown, work, live, and age and the wider set of forces and systems shaping the condition of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

How we address SDOH:

- Community Health Needs Assessment (CHNA)
- Community investment strategy
- Advocacy/public policy partnerships
- Cross sector solutions

Social needs

Social needs — personal, social, community, environmental and economic factors that when addressed, help individuals achieve physical and mental well-being.

How we address social needs:

- SDOH patient assessment
- Health education/promotion programs
- Capacity building of local community resources
- Closed loop referral system

SOCIAL DETERMINANTS OF HEALTH

Housing

Transportation

Social Support

Employment

Healthy Foods

Education

Economic Policies

Environment/Green Space

Asset-based Community Investment

Asset-based community investment is a tool to improve infrastructure and develop upstream interventions in all markets. Hospitals and health systems have an array of assets that can be harnessed to create healthier communities through community investment, including financial resources, land, expertise and relationships.

Community Health works with internal resources and a variety of partners in our local communities to make strategic financial investments that create, grow and enhance assets in order to benefit local residents and to address the social conditions that contribute to individual and community health. At a system level, investments can take the form of grants, loans, service agreements or contractual partnerships. Community Health helps broker these investments, ensuring long-term success and outcomes that positively impact both the people and places we serve.

Accelerating Investment in Healthy Communities (AIHC)

Accelerating Investment in Healthy Communities is a national program managed by the Center for Community Investment with support from the Robert Wood Johnson Foundation. It is designed to help health institution and community partners deploy assets (financial resources, land and expertise) to advance affordable housing as a way to create more equitable, sustainable and healthy communities.

Leadership from Community Health teams in Baltimore and Cincinnati participated in the cohort with five additional health systems to deepen commitment to affordable housing and advance policies and practices that foster equitable housing solutions.

Baltimore leveraged $1.1M to support the creation of a landbank in West Baltimore and the further development of three homeownership zones, creating new affordable homeownership opportunities in West Baltimore.

Cincinnati leveraged $300,000 to provide direct assistance to more than 170 renters, homeowners and landlords to avoid eviction and foreclosure during the COVID-19 pandemic. The project was nominated for the 2021 Inspire Healthcare Diversity & Inclusion Award by The Health Collaborative.

Direct Community Investment program (DCI)

In partnership with the BSMH Treasury team, Community Health supports the Direct Community Investment program, an initiative that utilizes BSMH's status as an Anchor Institution to provide capital in underserved communities. This helps us address social determinants of health and social and racial equity. The program currently services 23 loans across 16 partners, providing $2 million in new loans and nearly $5 million in renewed loans in 2021, creating a direct and positive impact in communities we serve.

Community Benefit

Community benefit reporting demonstrates the ministry's commitment to community service, documenting investments we make in our communities and maintaining our non-profit status. Community Health and Finance teams at both the system and local market levels are responsible for compiling and reporting community benefit data on a yearly basis.

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. Activities and programs must be an identified community need from the CHNA and improve access to health care services, enhance health of the community, advance medical or health knowledge, or relieve or reduce the burden of government or other community efforts.

Community benefit can include:

- Financial assistance
- Government sponsored means-tested programs
- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions
- Community building activities
- Community benefit operations

In 2021, BSMH was able to add $4.6 million in health professional education costs and $3.6 million in previously unreported subsidized services cost. Additionally, BSMH has contributed $18 million more in intentional community benefit spend in fiscal year 2021 compared to the same period in 2020.

Community Benefit Numbers (Unaudited)

Fiscal Year Ended December 31, 2021

(Thousands of dollars)

Traditional Charity Care		$94,835
Unpaid Cost of Public Programs		$371,582
Community Health Improvement Services		
Community Health Improvement Services	$36,205	
Health Professions Education & Research	$68,113	
Subsidized Health Services	$18,002	
Research	$549	
Cash & In-kind Contributions	$7,191	
Community Building Activities	$5,782	
Community Benefit Operations	$3,035	
TOTAL Quantifiable Community Benefit Services		**$605,293**

Community Partnerships

Building local, regional and national partnerships to support community-based work is a fundamental principle in the practice of community health. Local residents, stakeholders and community-based organizations are experts in understanding and determining what well-being means to them and what they need to advance their development.

Community Health promotes partnership development through evidence-based community engagement practices intended to solicit community voice, vision and preference on a range of health and community development related issues.

Community partners are a driving force in the success of BSMH community programs, investments and health outcomes. We cannot do this work without our numerous partners in each market.

Thank you for serving alongside us and welcoming BSMH into your communities!

In 2021, BSMH Community Health partnered with more than 60 community organizations and stakeholders.

Strategic Plan

Community Health system and market leaders collaborated to complete the 2022-2024 Community Health Strategic Plan. This plan is the first for Community Health and continues the theme of seeing health broadly to address health disparities, community infrastructure needs and department sustainability and growth.

The plan intentionally aligns with ministry-wide strategic pillars to ensure the greatest impact for the patients and communities we serve.

Community Health has set an ambitious goal to achieve 15 strategic milestones in 2022, ensuring strong foundational baselines that will support plan initiatives and create momentum for subsequent strategic plans.

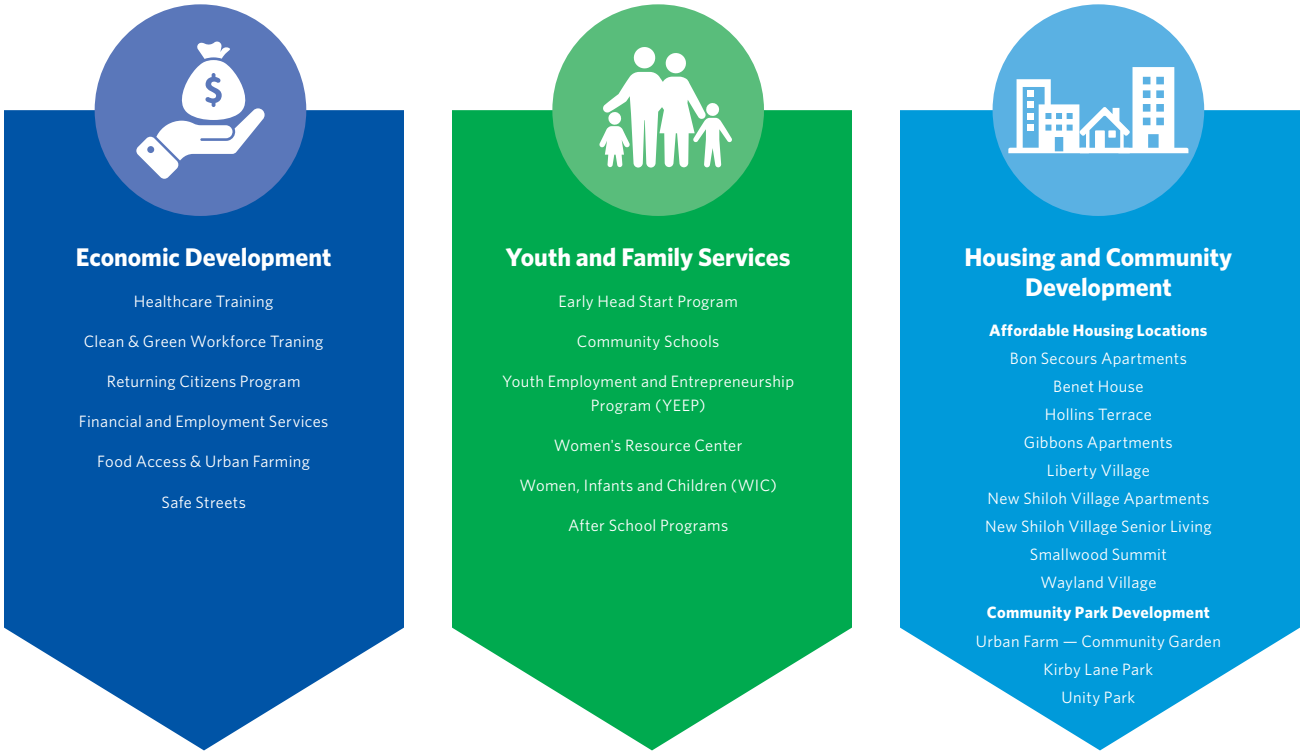
STRATEGIC FOCUS AREAS

PILLARS	FOCUS AREAS
Improve health and well-being	• Prioritized populations, placed based zones and community health focus areas • Health equality • Partner to address (disease) morbidity/mortality
Expand community development principles	• Innovate & diversified funding streams • Community engagement & participation
Partner to build scale	• Local, regional and national community health partnerships & collaborations • Safety net relationships
Cultivate investment & business development in the SDoH	• Support ministry revenue and cost savings • New business ventures

Community Health by Market

Baltimore

Working to enrich West Baltimore communities with programs and services that contribute to the long-term economic and social viability of neighborhoods, Bon Secours Community Works serves as a key community partner, with a 30-year history of improving well-being and neighborhood conditions. Despite the ongoing challenges of the COVID-19 pandemic, the organization delivered essential programming to low-income, at-risk individuals and families in West Baltimore, maintaining a strong commitment to local resident input and ascribing to the notion, "Nothing about me, without me."



Economic Development

Our economic development programs provide occupational skills training for in-demand careers, including those in the health care industry. Financial education and assistance are also available to participants. Community Works offered the following programs in 2021:

- Clean and Green and nursing assistant programs provided training in landscaping and health care fields.
- Returning Citizens Program served formerly incarcerated individuals by providing personal development training as a bridge to success at work and home.
- Job readiness training provided one-on-one career coahing and job placement assistance.
- Safe Streets Team addressed and interrupted violence, mediated tensions and connected the local community with programming and social supports.
- Low-cost tax preparation and Budget and Credit workshops educated on budgeting, savings, credit, credit repair and debt reduction.

Youth and Family Services

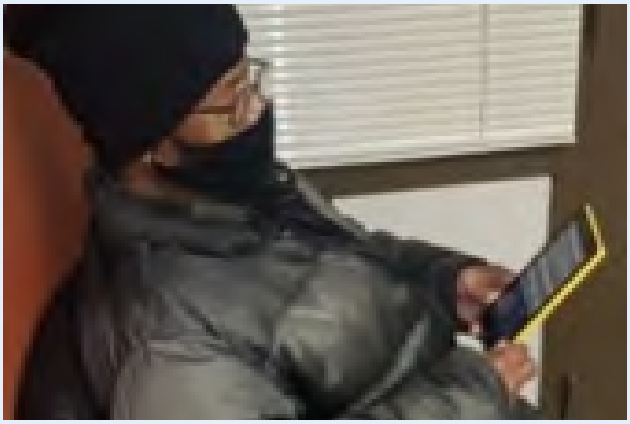
Programming provides young, at-risk families with parenting skills training, Early Head Start Developmental childcare, family literacy education, health education and various support groups (e.g., teen parents, young fathers, etc.).

- **More than 60 children were enrolled in Early Head Start in 2021.**
- The **Youth Employment & Entrepreneurship Program** provided **29 youth and young adults** ages 14-21 an opportunity to explore careers and gain job readiness skills.

Due to COVID-19 hardship, rent delinquencies jumped to 15%. Residents behind on rent were able to participate in our Financial Education & Eviction Assistance Program, a newly created pilot to deal with consequences of the pandemic.

- **40 residents** completed the program.
- **$48,000 in rent assistance** was provided to protect an **additional 40 households** from eviction, helping them remain in their current homes.

3,100+ people were served by Bon Secours Community Works programs



Housing and Community Development

The need for quality affordable housing continues to be great in West Baltimore. As a result, Community Works **manages more than 800 units of affordable rental housing** for low-income families, seniors and individuals with disabilities. Coordinated resident services are available for those that need assistance with a myraid of services. In 2021, building improvements and resident services included:

- No cost Wi-Fi was installed in each of our eight apartment buildings.
- Residents received training on accessing Wi-Fi service and operating hardware.
- Residents were provided free tablets to take advantage of the Wi-Fi service.
- A back-up generator was installed at Smallwood Sumit senior living facility.
- **18 vaccination clinics were held at our senior buildings, enabling 359 residents to be fully vaccinated for COVID-19.**

Food Access Program

Our Food Access Program continued to purchase, pack and deliver healthy food as well as basic household cleaning supplies to 145 families. Based on client feedback, we now include recipe cards for healthy meals and all the ingredients to make at least one of those meals. We also surveyed families in order to customize food items based on their children's ages.

Capital Projects

2021 saw the completion of a **$1.2M renovation of the first floor of the Bon Secours Community Works facility** at 26 N. Fulton Ave., supporting the expansion of the Early Head Start program. The **second phase of Kirby Lane Park was also completed,** which included installation of benches, a walking track and swing set. The **Bon Secours Community Resource Center was completed,** transforming a long, vacant library into a new and expanded space for community programs and social services, including Community Works. The space will offically open in early 2022.

2022 Projects and Goals

1. Planning and designing for complete renovation of the second floor, parking lot and playground area of the North Fulton Ave. facility.

2. Construction of Unity Park, a $1.45 million splash and play park co-located with Bon Secours Apartments.

Cincinnati

Operating five hospitals in Hamilton, Butler and Clermont counties, Mercy Health Cincinnati participates alongside other area health systems and community stakeholders to identify and prioritize community health needs for the region. Feedback from community meetings, consumer surveys and local health departments and agencies resulted in five identified priorities and recognition of infant mortality as key areas of continued focus for Mercy Health and its collaborative partners for 2020 – 2022. Mercy Health Cincinnati also introduced an intentional emphasis on cross-cutting priorities and at-risk populations, centering equity and elevating social determinants as a point of consideration in the development of all community health strategies.

All five hospitals are addressing the following needs:

- Substance abuse
- Mental health
- Access to care
- Chronic disease
- Healthy behaviors
- Infant mortality

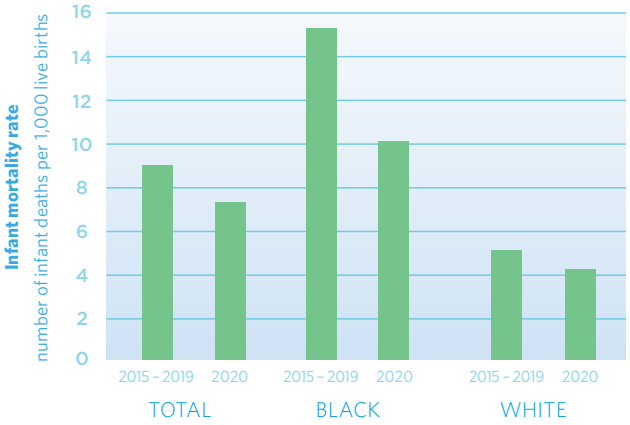
Mercy Serves

A unique partnership with ServeOhio and the National Corporation for Community Service (CNCS), Mercy Serves placed AmeriCorps Members alongside Emergency Department staff to promote critical support to patients with opiate use disorders. The service-learning experience helps build the next generation of service-minded health care leaders. Mercy Health **hosted five AmeriCorps members** and ended the service with a **100% retention rate.** The team also provided **support for over 45 COVID-19 vaccine clinics where over 4,000 vaccines were administered.**

Infant Mortality Response

Mercy Health Cincinnati is a longstanding funder and active participant in Cradle Cincinnati, a nationally recognized collective impact initiative aimed at reducing infant mortality in Hamilton County. The collaboration has led to a steady decline in overall infant deaths and a narrowing in the racial disparity among Black and white families. Indicators for 2021 show positive trends that continue the success of 2020, which saw a 20% decline in infant mortality and the Black infant mortality rate drop below the national average of 10.8.

INFANT MORTALITY RATE, HAMILTON COUNTY, 2015 – 2020



Perinatal Outreach Program

The partnership with Cradle Cincinnati helped launch Mercy Health's perinatal outreach program, which focuses on services and supports to African American women in high-risk neighborhoods adjacent to Mercy Health hospitals. Founded in 2020, **the program has served 114 women in 2021, and 168 since its inception.** The program continued to show promising outcomes in 2021, with less than 10% of babies born to program participants being delivered preterm, none born extremely preterm and 92% born at normal birthweight.

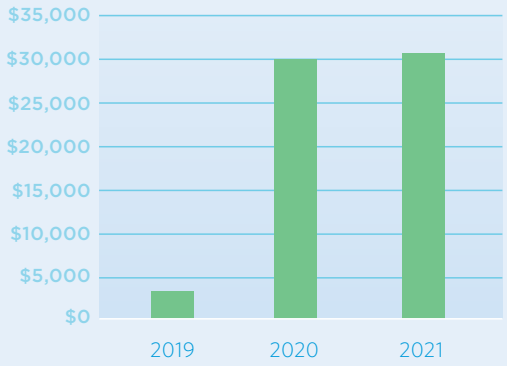
Mercy Health Partnership Program

Mercy Health Partnership Program utilizes a team of three licensed social workers to provide supportive services for uninsured/underinsured patients or those at risk for losing coverage. In 2021, the program **celebrated its 25th anniversary** and had over **3,000 patient encounters with over 670 patients assisted specifically with obtaining Medicaid, Marketplace, and Medicare, financial assistance and other benefits.**

Partner Spotlight

In 2019, Mercy Health Cincinnati launched a partnership with Produce Perks Midwest to address individual barriers and community conditions leading to food insecurity and disparate health outcomes in underserved communities. The partnership provides nutrition prescriptions, healthy food vouchers, and other incentives to assist financially challenged families struggling with nutrition-related illness. Additionally, Mercy Health Cincinnati's partnership with local corner store Gracely's Food Mart aims to increase the availability of produce in target neighborhoods. In 2021, **more than 80% of monthly produce sales come from Produce Perks participants.**

PRODUCE PERKS PURCHASES AT GRACELY FOOD MART



Community Clinics

Mercy Health offers critical primary care access for uninsured and underinsured patients in underserved communities. The clinics address barriers to care, reduce unneeded ED utilization and alleviate the cost burden for financially strained patients by providing free care and ensuring timely appointments.

1,000 patients served on an annual basis

Mobile Mammography

Mercy Health currently has two mobile units offering mammogram screenings at various locations throughout the Greater Cincinnati region. The mobile vans offer a full suite of screening resources needed for early cancer detection and intervention.

3,244 patients served at 324 sites

2022 Goals and Programs

1. Prioritize partnerships, programs and community interventions that address social determinants of health, with a focus on food and housing.

2. In 2022, Mercy Health Cincinnati will expand their team to include two newly developed positions, Director of Community Health Programs and Manager of Community Health Strategy, to bring enhanced capacity and focus to community health across the region.

Greenville

In 2021 the Community Health team extended the compassionate ministry of Jesus to address the challenges of a global pandemic and serve the community in more innovative ways. In early 2021, the Bon Secours St. Francis team helped staff COVID-19 clinics and managed a local vaccine hotline. The team also offered COVID-19 and flu vaccine clinics and educational events in partnership with faith-based community organizations, health care organizations and other nonprofits, including the Urban League of the Upstate, NAACP, Hispanic Alliance, SC Department of Health and Environmental Control, Greenville Free Medical Clinic, Unity Health and several churches. Throughout the year, the Bon Secours Greenville team continued to make progress on pre-pandemic prioritized needs as identified by the community, including:

1. Affordable housing

2. Behavioral health

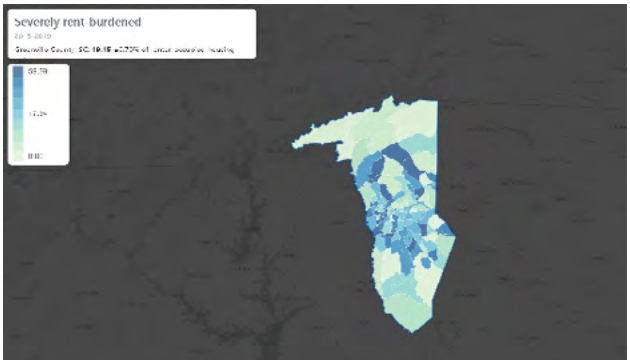
3. Obesity reduction

Sterling Land Trust & Mercy Housing Affordable Housing Projects

Bon Secours St. Francis provides support to Sterling Land Trust initiatives to build affordable housing in the Sterling Community, an underserved, historically African American neighborhood. The Sterling community and Bon

Secours partnered with Clemson University urban design and landscape architect graduate students to design future projects, advancing the strategic vision for the neighborhood.

Bon Secours St. Francis also partnered with Mercy Housing SE to **develop 46 affordable housing units in Greenville County.** The project includes one-, two- and three-bedroom units with health education support provided by the ministry.



Community Behavioral Health Needs

The Greenville Market's behavioral health team implemented the Columbia-Suicide Severity Rating Scale (C-SSRS) which is used in combination with the already-established Patient Health Questionnaire (PHQ-9) for depression screening in ambulatory settings. To **help alleviate the shortages of behavioral health workers in Greenville, the health system hired two additional nurse practitioners and one additional social worker.**

Reducing Poverty in Greenville County

In 2021, Bon Secours St. Francis' Wellness Outreach team replicated the African American Faith-based health model in targeted Hispanic communities by offering several "Take Care of Your Heart" and chronic conditions awareness events. Participants received healthy recipes in both Spanish and English, salt-free spice mixes, boxes of fresh produce and educational materials on maintaining healthy blood pressure and preventing chronic disease. **More than 90 community residents participated in the program.**

The Wellness Outreach team also worked in partnership with Hispanic faith-based organizations to implement family-focused obesity prevention strategies aimed at reversing the increasing trend of obesity in Hispanic children. The team **held healthy eating presentations at 7 Hispanic churches** throughout the community. The pandemic increased the number of Hispanic families facing food insecurity. To address the growing need, local staff worked with partners including Mill Village Farms and Loaves and Fishes to distribute healthy foods accompanied by recipes and food-based education flyers.

Healthy Outcomes Program (HOP)

HOP, a health improvement program developed in lieu of Medicaid expansion in South Carolina, focuses on low-income, uninsured patients with chronic diseases. In addition to improving the health of underserved patients, the purpose of the program is to avert preventable emergency room visits and inpatient stays by helping patients manage their conditions and establish primary care homes. The HOP team also addresses barriers related to social determinants of health by providing solutions to transportation and medication access and **maintaining ongoing contact with 582 active enrollees.** Through grant funding, the program was able to provide small medical devices (spirometers, blood pressure cuffs, oxygen meters, and scales) to encourage patients to monitor and take responsibility for improving health at home.

HOP online COVID-19 education sessions were viewed over **8,400 times**

2022 Goals and Programs

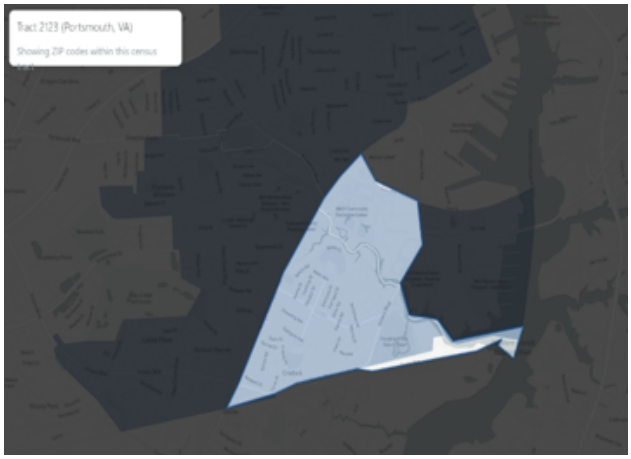
1. Partner with Mercy Housing SE, Sterling Land Trust and Habitat for Humanity to create more than 90 new units of affordable housing for local seniors and others in need.

2. Reduce the provider shortage and increase the availability of behavioral health assistance by hiring one additional psychiatrist and one additional therapist in 2022. The market will also be an active participant in the Greenville Well Being Partnership to address county mental health needs.

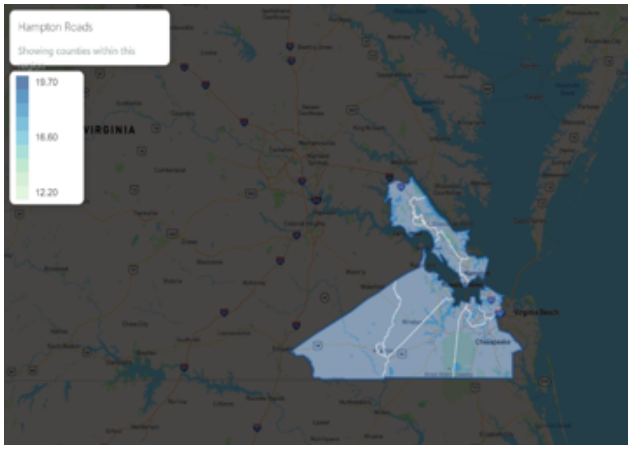
3. Continue to participate in programs and partnerships with faith-based organizations to offer educational health events directed at reducing obesity in Greenville County, particularly in the Hispanic community.

Hampton Roads

Bon Secours Hampton Roads is committed to addressing the physical, emotional, and spiritual well-being of the communities we serve. Community Health programs and services are offered throughout Hampton Roads, including Portsmouth, Norfolk, Newport News, Franklin, and Suffolk.



Cradock Focus Areas



Hampton Roads Primary Service Area

Identified community priorities include:

1. Chronic Conditions (Heart disease, diabetes, obesity)
2. Opioid and substance use
3. Mental health
4. Affordable housing
5. Workforce development

Care-A-Van

By reducing barriers to access to health care, the Bon Secours Care-A-Van is a free medical service that provides general medical care to uninsured adults and children in Hampton Roads communities on the southside and the peninsula.

800 individuals served with Care-A-Van

Passport to Health & Family Services

The Passport to Health program offers health and wellness education, focusing on improvements in health literacy, healthy food awareness and physical activity awareness. Bon Secours Hampton Roads operates two cohorts, **engaging 50 families in the program.** The Family Services program **served nearly 1,000 families through ESL and family resiliency classes.**

Affordable Housing Support & Community Investment

Community investments of more than $6.5 million was utilized to address affordable housing, food insecurity and small business incubation.

Bon Secours Hampton Roads continues to support **1,800 units of affordable housing** through partnerships with Community Housing Partners, VA Supportive Housing and Commonwealth Catholic Charities.

2022 Programs and Goals

1. **Implementation of Pathways to Resiliency:** Resiliency is defined as the capacity to recover quickly from difficulties. Through our "Pathways to Resiliency" framework, we will address the individual, household and community contexts to make a positive impact on the social determinants of health in order to improve health outcomes.

2. **Welcoming Programs and Partners into Community Health Hub:** In 2021, we established the Community Health Hub, a multiservice center that provides resources and education to residents of the Cradock and the Greater Hampton Roads community. Services available include COVID-19 and flu vaccinations, blood pressure screenings, health education, Care-A-Van services and medical school education. We look forward to welcoming community partner organizations into the Community Health Hub in 2022 to expand services to include financial literacy, housing counseling and other expressed needs for the community.

3. **Expansion of Efforts into Franklin, VA submarket:** To ensure we are meeting the needs of the Franklin community, Community Health plans to expand several of our signature programs, including providing care to the uninsured through the Care-A-Van, partnering with local congregations to offer the Passport to Health program, and developing a community farm model to reduce barriers to food access for the underserved in the community.

Irvine

Mercy Health — Marcum and Wallace Hospital is dedicated to the communities we serve. Using the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) as our guide, we strategically address the needs of our patients, community partners and stakeholders.

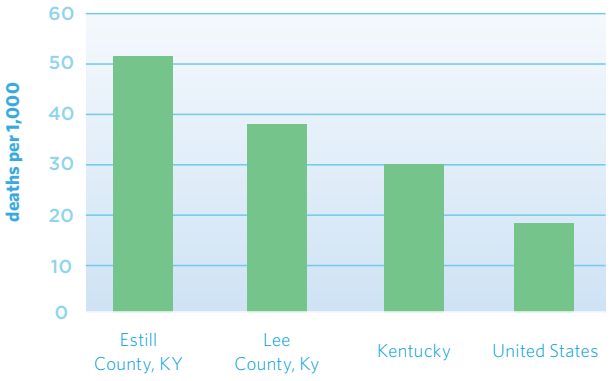
Prioritized community health needs and strategies identified by the community include:

- Substance abuse
- Mental health
- Obesity

Drug Enforcement Administration Take Back Day

Mercy Health — Marcum and Wallace Hospital participated in a Drug Enforcement Administration (DEA) Drug Take Back Day and **collected 62 prescription medications.** Studies indicate a majority of abused prescription drugs come from family and friends, including from home medicine cabinets, which makes clearing out unused medicine essential.

DRUG OVERDOSE MORALITY, 2013 – 2017
ESTILL COUNTY, KY AND COMPARISON



Mercy Health — Marcum and Wallace Hospital **was awarded a $32,418 grant by the Bureau of Justice** to partner with St. Claire Regional Medical Center and Northeast Kentucky Area Health Education Center to provide virtual curriculum for opioid prevention activities and substance abuse to Estill County and Lee County high school students.

Mental Health Interventions

The local market was awarded a Behavior Telehealth grant that allowed a licensed clinical social worker to provide **168 behavioral health encounters to local patients.**

Obesity Programming

In partnership with the local BSMH Foundation, the hospital provided access to healthy foods (fruits, vegetables and proteins) to 100 qualified patients each month and facilitated the distribution of 220 family meal kits that provided education on healthy food preparation and families eating at home.

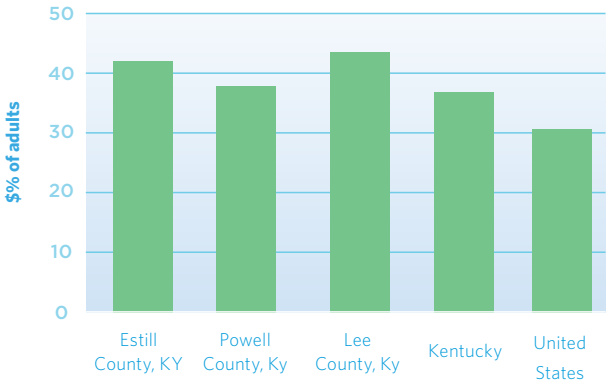
220 family meal kits distributed

100 qualified patients received food support each month

Leaders from Mercy Health — Marcum and Wallace Hospital distributing healthy family meal kits to community members in August 2021.

OBESITY, 2018

ESTILL COUNTY, KY AND COMPARISON



COVID-19 Response

Partnering with the University of Kentucky Center of Excellence in Rural Health (UK CERH), Kentucky Homeplace and a network of community partners, Mercy Health worked to increase local COVID-19 vaccination rates in Estill County through more than $3 million in grants from the U.S. Health Resource Services Administration. The goal of the program was to improve COVID-19 vaccination rates in Appalachian Communities by increasing community outreach in remote communities, removing barriers to vaccine access, assessing needs of individuals, providing education and increasing positive messaging.

Marcum and Wallace Hospital associates participating in the October Appalachian Community Health Day to provide COVID-19 vaccination access, community resources and health screenings to community members.

Prescription Assistance

In 2021, **132 manufacturer assistance program applications were completed for 81 patients.** The total amount of medication assistance acquired for these patients was valued at more than $630,000. Local pharmacy teams **assisted an additional 200+ patients with prescription cost issues.**

2022 Goals and Programs

1. Mercy Health — Marcum and Wallace Hospital has applied for 2022 grant funds to continue efforts addressing barriers to access and education surrounding healthy foods and activities to promote health and well-being in the communities we serve. Current efforts have collectively served 320 community members. In 2022, there are plans to expand on the geographical footprint for healthy meal kit events and monthly food resources provided to community members in need.

2. The market plans to address transportation as an additional barrier to care, programs and assistance. The addition of transportation to social determinant of health programming will help create a more holistic approach to addressing wellness locally.

3. The Project Home team will continue to address substance abuse and mental health needs within the local service area by increasing staff capacity, exploring new grant opportunities and creating new community partnerships.

Lima

Serving Allen, Auglaize, and Putnam counties, Mercy Health Lima is focused on the health and well-being of our patients and service to our community. Combining quality and compassion is what Mercy Health — St. Rita's Medical Center has been known for throughout our more than 100-year history, and it remains our commitment to our community in the years to come. This longstanding commitment has evolved intentionally based on our communities' most pressing health needs. We address these needs by ensuring our resources for outreach, prevention, education and wellness are directed toward opportunities where the greatest impact can be realized. Through this we can reach those who are poor, dying and underserved, and help to eliminate the many health disparities and barriers that directly influence our community's current greatest health needs.

Prioritized Health Needs

1. Chronic disease
2. Mental health and addiction
3. Maternal and infant health
4. Access to health care
5. Social determinants of health
6. Public health system, prevention and health behaviors

Partner Spotlight: Activate Allen County

Mercy Health partners with Activate Allen County to educate and inspire people in the community to make healthy choices. Activate Allen County also works to educate people about the relationships between policy, environment and community design and how it can impact health and well-being.

Together our organizations have partnered on numerous programs that bring sustainable health change to the community, including collectively improving the health and well-being of over 6,500 students through outreach strategies and initiatives.

South Jackson Community Gardens

Activate Change QUIT Tobacco Cessation Program

A new pilot project designed to support and promote smoking cessation, Activate Change QUIT offers a 12-week phone support program option that connects patients to pharmacists, respiratory therapists and clinical psychologists or a mobile clinic option that connects patients to a tobacco treatment specialist and pharmacist. Both options coordinate services with patients' primary care providers and serve as a training opportunity for student pharmacists. **2021 saw 221 program referrals, 42 participants complete the program, 70 new patient visits and 616 total patient contacts. Collectively, the program saw 27% of participants remain tobacco-free at 30 days of the program, and 60% for 180 days. There was reduction in Packs Per Day (PPD) from 1.21 to 0.47.**

Green Prescription Program

Eight family practice offices in Lima screen patients for food insecurity. The Green Prescription (Rx) program is a new, collaborative pilot project designed to help address food insecurity by removing barriers to overall food affordability and food access. Approximately 46% of residents have low food access (food store further than half a mile away in urban areas and 10 miles away in rural areas) and 45% receive SNAP benefits. **The program has assisted 35 patients in addressing their food insecurity.**

Art Therapy

As an identified strategy to help address mental health/addiction and promote alternative therapies, Art Space of Lima has partnered with Mercy Behavioral Health to offer art therapy to patients. Participants are given a pre- and post-assessment to measure the effect of art therapy on indicators such as stress, mood, energy levels and ability to process emotions. **In 2021 there were 321 assessments completed, with 63% of patients showing improvement in 4 out of 7 indicators.**

Prostate Disparities Program

Holding four Neighborhood Block Parties in distressed census tracts throughout the community, the Mercy Health Lima team **screened more than 165 individuals' health insurance status, primary care provider status, social determinant needs and date of last preventative cancer screenings.** Additionally, 39 African American men were screened, providing 4 referrals to primary care and an appropriate PSA screening. The program also deployed a **newly created diversity and inclusion outreach coordinator** to help address health disparities, build relationships with the community (especially minority populations) and build health career pipelines for those who have been historically underserved.

2022 Programs and Goals

1. Develop and implement a place-based disparities programming model that will evaluate and strengthen access to care for underserved individuals within Allen County. The project will aim to connect at least 500 at-risk individuals in our community to established services and care.

Lorain

Since its founding by the Sisters of Humility of Mary, Mercy Health has supported the health needs of Lorain County for 129 years. The organization has ensured that the mission has lived inside the walls of all our facilities and throughout the community. The pandemic ignited new challenges to providing care to the community, ensuring access to facilities and most importantly adapting to the changing needs in the community. These challenges were answered by listening to those we serve both within our facilities and in the communities. Throughout 2021, Mercy Health Lorain was able to deliver programs and care that kept patient safety first and reminded patients that their community hospitals and facilities are here to serve. Programs addressed identified priority needs including:

- Chronic disease in men and women
- Mental health
- Substance abuse
- Social determinants of health
- Cancer — breast, prostate, colon
- Access to care
- Mother and infant care

Family Outreach: Adopt a Child

Mercy Health Resource Mothers Program collaborates with local churches and Mercy Health Community Health Department to donate Christmas gifts to children in need. **In 2021, 425 children received gits under their tree for Christmas.**

Rising Stars Program

The Mercy Health Lorain Market began its 18th year of the Rising Stars Program in 2021. The program is committed to increasing the diverse pipeline into health care careers. This year, **15 students participated in the program, bringing total lives impacted to 98 over the duration of the program.** In 2021, Jordan Brown became the first Rising Stars participant to graduate from medical school. Six additional Rising Stars students are on track to graduate medical school in the coming years.

School Supply Drive

The Mercy Health Community Health team is proudly committed to collecting school supplies for local students. In light of the pandemic, it was more important than ever to provide for the children of Lorain County. **We received over 4,000 donations, including 51 filled book bags for a local Pathways Program.**

Parish Nursing: United in Glory

COVID-19 impacted the Lorain community in many ways, including individuals' ability to access care. To stay connected with patients, Mercy Health Lorain held community Zoom meetings, including one with the Lorain County Black Pastor's organization. During monthly Zoom calls that highlighted the status of the pandemic, local staff learned that many congregation members of color were concerned as to why they were being impacted more by COVID-19 than others.

With this feedback, the Mercy Health Parish Nursing team created a group for individuals seeking support to manage chronic disease outcomes to both alleviate their fear around their

numbers and strengthen the foundation of their health. The program, United in Glory, graduated its first class in May of 2021 with great improvement in Quality health measures by all 31 participants. With physician partner Dr. Robert Thomas serving as coach, motivator and educator, program participants saw improvement in the following metrics:

Metrics	What they mean	Impact / Change
Weight / BMI	How much mass your body has	121 / 28.6
Waist Circumference	The number of inches around your mid-section; shows an impact on your cardiac metrics	136.18
Blood Pressure	How easily your blood flows through your veins	Systolic — Decrease on average of 30 points Diastolic — Decrease of average of 10 points
HbA1c	90-day blood glucose average	10.2
Cholesterol	Total Cholesterol HDL LDL	HDL — 83 points total

Dr. Robert Thomas and Pastor Terrence Bivins

2022 Programs and Goals

1. Implement United in Glory 2.0 with greater connections to needed testing. In addition, implement two more programs in partnership with Mercy Health Physicians.

2. Begin development of a Food Prescription Program/Partnership with Lorain County Public Health.

3. Continue Ohio Department of Health grant work with both Pathways and Moms and Babies First.

Paducah

Mercy Health — Lourdes Hospital serves a population of more than 200,000 people within its seven-county, two-state (Kentucky, Illinois) primary service area. The market area serves nearly 14,000 uninsured individuals and a higher-than-state average percentage of individuals with disabilities and people over 65 years of age. Programs and interventions have been developed with these priority populations in mind. Significant health needs identified by the community include:

1. Access to care
2. Cancer treatment
3. Chronic illness
4. Mental health
5. Obesity
6. Oral health
7. Substance abuse

Of identified needs, the following health needs have been elevated as priority:

1. Cancer treatment
2. Mental health
3. Substance abuse
4. Chronic illness

Project United

Mercy Health was proud to assist the Paducah Cooperative Ministry on projects for the United Way Paducah-McCracken County's Project United Day of Service. Team members spent a morning organizing a donation garage to benefit local clients and partner agencies. Paducah Cooperative Ministry seeks to do God's work with human hands by bringing together individuals and resources to respond to basic human needs and conditions in McCracken County.

Housing Authority Community Day

Mercy Health was proud to serve as a co-presenting sponsor for the Housing Authority of Paducah's Community Fun Day. Representatives from Mercy Health Midtown Pediatrics and Mercy Health Behavioral Health were there to provide giveaways and health education to attendees.

Substance Use Outreach

Mercy Health — Lourdes Hospital partnered with the Purchase District Health Department to distribute free Deterra bags to those leaving the hospital with an opioid prescription and free Narcan nasal spray to at-risk patients discharging after an overdose. **Pharmacy distributed 500 Deterra bags in 2021.** Lourdes also partnered with the Paducah Police Department and Purchase District Health Department for DEA Drug Take Back Day. Holding events in the spring and fall on the hospital campus, **429 pounds of items were collected and given to the DEA for proper disposal.**

Free Flu Shot Program

In an effort to expand access to the influenza vaccine, Lourdes, with funding from the BSMH Mission Outreach Program, partnered with a variety of organizations to distribute the flu vaccine throughout the region without charge, specifically

targeting those populations that are not usually vaccinated due to various access barriers and challenges (e.g., lack of insurance or limited financial resources). Partnering organizations included affordable housing sites, churches, non-profit human services organizations and public libraries.

2021 outcomes included:

- **15 events throughout 3 counties**
- **400 doses donated to four non-profit organizations**
- **508 doses administered at community events**
- **16 community partners developed or sustained**

Homelessness Initiatives

Homelessness has been identified as a rising local need in western Kentucky, further enhanced by the COVID-19 pandemic. Lourdes Hospital partnered with the United Way of Paducah-McCracken County to fund an AmeriCorps VISTA position with the Homeless and Housing Coalition of Kentucky. The VISTA (Volunteers in Service to America) position works with the community to help individuals and families find ways out of poverty and decrease housing insecurity, also offering direct service to those in need.

COVID-19 Vaccine Education & Outreach

In an effort to reduce local COVID-19 vaccine hesitancy, Lourdes made a strong push for vaccine education and outreach. The market held multiple virtual events and town halls where questions were answered by market Chief Clinical Officer Dr. Jenny Franke. Internally, over **200 associates attended six town hall meetings.** In the community, Lourdes partnered with the Graves County Health Department to promote the Foundation for Healthy Kentucky's "I Got the Shot" Campaign, addressing hesitancy specifically among Black Kentuckians by naming and responding to some of the most prominent concerns. The campaign featured two Lourdes employees.

Partnership Spotlight

Lourdes sponsored a community garden on the property between the local Senior Center and a Housing Authority of Paducah site. The community garden project will support efforts to promote and encourage a healthy lifestyle in older adults and mitigate the effects of social isolation.

2022 Projects and Goals

1. Two large primary care practices in Marshall County will pilot a Fresh Food Program in the spring of 2022 for 30 at-risk patients. Patients for the program will be selected based on financial need and clinical conditions such as high BMI and diabetes. Patients will enroll in the six-month pilot, which will provide access to fresh fruits, vegetables and proteins from a local grocery story and will be tracked monthly for health improvements including weight checks and blood pressure. Organizations partnering with Lourdes on this program include the Marshall County Health Department, Murray State University and Purchase Area Diabetes Connection.

2. Lourdes will implement a new feminine hygiene product access and education program in rural western Kentucky. The scarcity of puberty education and limited access to feminine hygiene products affect menstrual management for economically disadvantaged young girls, contributing to stigma, shame, fear and anxiety. The program will provide adolescent patients with a three-month supply of feminine hygiene and care products during their OB-GYN or pediatrician appointment, as well as assist in referring them to the Family Resource Officer at their school to ensure they have continued support beyond the three-month interventions.

Richmond

Bon Secours Richmond has a rich history of progressively addressing key social, disparity and infrastructure factors that have negatively affected our most vulnerable neighbors. Through community partnership and direct services, Bon Secours Richmond serves people who experience the generational effects of poverty, race and equity on where they live, work, and gather.

For over 10 years, Bon Secours Richmond has engaged with stakeholders in the East End to listen to community voice and to be a solution partner to address identified needs. During the pandemic, our commitment to solutions grew as we had to become nimbler, more creative and better listeners to evolving community needs.

$3,106,583
2021 Community Investment

$34,000,000
leveraged across 41 non-profit partners across 8 counties

Solutions to address priority health and well-being needs were established by local stakeholders and community residents. Priorities include:

- Chronic disease
- Community livability
- Educational achievement
- Economic equity
- Access to care
- Behavioral health
- Social determinants of health
- Stress and trauma

Special focus was placed on the following areas:

Chronic disease	• Diabetes • Heart disease, stroke, cancer, COPD, obesity • Access to health care services and health education • Access to healthy and affordable food
Behavioral health	• Opioid use • Substance abuse, alcohol/ drug use • Mental health and suicide • Homelessness
Social determinants of health	• Transportation • Housing • Education and school system • Jobs with fair wages
Stress and trauma	• Child abuse/neglect • Community violence and crime • Domestic abuse

Instructive Visiting Nurse Association (IVNA)

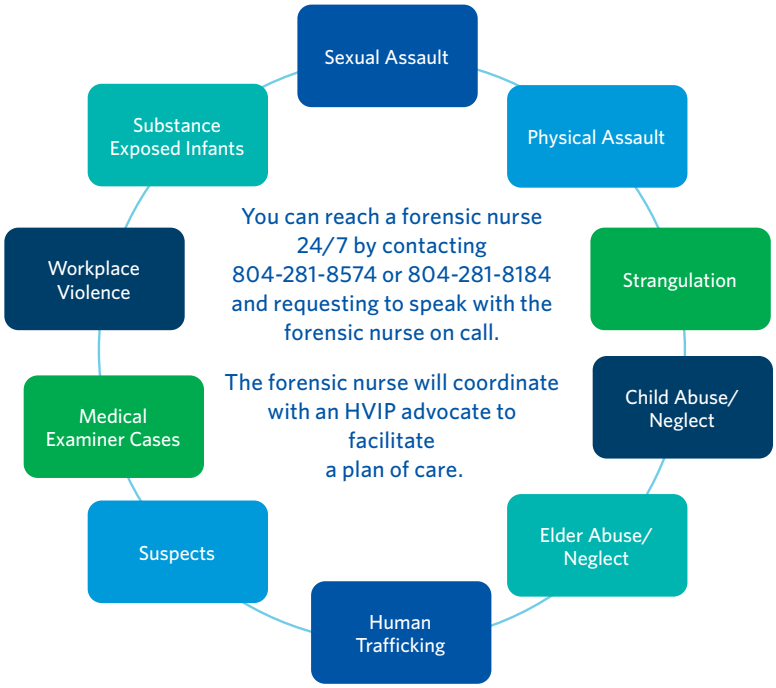
Founded in 1900, the Instructive Visiting Nurse Association (IVNA) started with 14 nurses who believed some patients were being discharged from hospitals too early, primarily because of racial and economic disparities. Today, IVNA continues to provide important health services to vulnerable patients throughout central Virginia. **Partnering with over 450 businesses, faith-based institutions, schools and community partners,** IVNA provides flu clinics, biometric wellness screenings, TB clinics, Hepatitis B clinics, health education, homebound immunizations and COVID-19 vaccines. **In 2021, IVNA provided over 10,000 COVID-19 vaccines to front line health care workers, first responders and some of the most vulnerable individuals in our communities.**

Every Woman's Life (EWL)

Every Woman's Life program coordinates no cost mammograms and pap smears for uninsured women throughout the state of Virginia. The program enrolls women ages 40 – 64 years of age with an income under 200% of the Federal Poverty guidelines. Additionally, women between 18 – 39 years of age with a previous abnormal pap test or breast lump can also qualify for no cost screenings through the program. **Annually, over 900 women receive services through this program.** More than half of the women served are also patients of our local Care-A-Van mobile health van that provides comprehensive primary care to uninsured patients throughout the region.

Care-A-Van

For 25 years, the Care-A-Van mobile health team has served the most vulnerable throughout the Greater Richmond community. As a first-come, first-served mobile clinic, the program uses telephone triage to assess patient needs and offers same-day comprehensive primary and specialty care services as well as scheduled appointments for routine follow-up care. A team of bilingual (English/Spanish) physicians, advanced practice clinicians, registered nurses, licensed practical nurses, certified medical assistants, drivers, registrars, trained medical interpreters, registered dieticians, licensed clinical social workers, community health workers and outreach workers provide comprehensive primary care to nearly 6,000 uninsured adults and children across more than 13,000 visits annually, including chronic disease management pediatric immunization and resources to address social and economic needs. **2021 saw 17,981 unique patients receive care via the Care-A-Van.**



Forensic Nursing Program

Forensic nurses provide community outreach, including participation on multiple sexual assault and child abuse response teams. They serve as presenters on sexual assault, human trafficking, strangulation, child abuse, elder abuse, domestic violence and intimate partner violence. The Bon Secours Richmond program is one of only a few programs across Virginia to be staffed 24 hours a day, seven days a week, serving patients of all ages. The program serves 42 jurisdictions and collaborates with law enforcement, attorneys, child advocacy centers, shelters, social services and victim witnesses. Patients receive medical care that may include history taking, head-to-toe assessments, photography and evidence collection.

COVID-19 Pandemic Response

At the onset of the pandemic, all 13 Care-A-Van church partners closed their physical spaces for safety precautions, leaving the program without physical space to provide face-to-face care. Within

24 hours, the Care-A-Van team set up a telemedicine system for the new and established patients requiring care, keeping them out of emergency rooms when appropriate and establishing a lab facility within the Sarah Garland Jones Community Room. Within a matter of days, Care-A-Van launched a comprehensive virtual platform allowing patients to receive care through video and audio from the comfort and safety of their home or workplace. Care-A-Van provided care to # patients via virtual care.

5,000 COVID-19 vaccines given to date

Food Rx Program

The Food Rx Program is a prescription produce program that brings together fresh, local produce and education to improve health and increase consumption of fruits and vegetables. Through a partnership with Shalom Farms, participants and their families receive one serving of produce per family member each day for 12 weeks and also participate in education and hands-on learning. Education programs are available in both English and Spanish. **The program served 20 families in 2021.**

2022 Goals and Programs

1. Increase access to health care by completing construction of our fixed site care clinic and opening our doors for more effective care for the uninsured struggling with chronic disease and behavioral health issues.

2. Increase in-person and virtual engagement with communities and neighbors through social, wellness and educational programming while continuing to nurture partnerships with local pastors and nonprofit leaders committed to uplifting the most vulnerable in the community.

3. Increase the capacity of forensic nurses from 40 hours a week at Southside Medical to at least 160 hours a week while also working with the Richmond Workplace Violence Committee to help standardize the response to workplace violent events.

Springfield

Through the work of two hospitals, Mercy Health — Springfield Regional Medical Center and Mercy Health — Urbana Hospital, Mercy Health Springfield has been committed to the communities it serves for more than 150 years. Local work serving both Clark and Champaign counties included addressing prioritized health and well-being needs identified by the community.

Clark County Prioritized Needs	Champaign County Prioritized Needs
1. Health risk prevention	1. Health risk prevention
2. Healthy living	2. Healthy living
3. Access to care	3. Behavioral health (mental health, addiction, trauma)
4. Behavioral health (mental health, addiction, trauma)	4. Chronic disease (congestive heart failure, COPD, diabetes, cancer)
5. Chronic disease (cancer, heart failure, diabetes, COPD)	5. Access to care
6. Maternal and infant health/ infant mortality	6. Maternal and infant health/ healthy births/ infant mortality

Faith Community Nursing & Health Ministry Program

Addressing health risk prevention, healthy living, chronic disease management and access to care, this pilot program engaged five churches in one target neighborhood with identified boundaries of Pleasant Street to Perrin Street, S. Limestone Street to S. Yellow Springs Street. Program staff has worked collaboratively with the church parishioners, congregations and leadership to identify candidates to serve as faith community nurses or health ministers. **Nine individuals are completing training.** The program has also

completed four congregational assessments. Additionally, congregations have connected with Springfield Fire & EMS to begin a CPR training class for congregants. Congregants have also partnered with Clark County Combined Health District to provide COVID-19 vaccination and testing outreach.

Mercy REACH: Drug, Alcohol & Tobacco Cessation

Mercy REACH provides medically assisted treatment through vivitrol injections and medically assisted detox through Springfield Regional Medical Center. The REACH team spends a significant amount of time and resources connecting with the community, providing education and prevention services with both juvenile and drug courts, referring to treatment through our local one-to-one clinic partnership, Grow Outreach (overdose awareness and Narcan distribution) as well as serving on our local community substance abuse and prevention coalitions.

8,500 served to date in 2021

+26,000 patient have been served over the last 3 years

Mercy Health Community Medication Assistance Program

Med Assist receives referrals from local physicians, hospitals and social service agencies. Qualified patients receive monthly vouchers for medication assistance.

8,536 served to date in 2021

Spotlight Partnership

Second Harvest Food Bank has been a strong partner of Mercy Springfield in addressing hunger as a social determinant of health. In 2020, Mercy Health Foundation of Clark and Champaign County committed $50,000 and strategic resources supporting collaboration and partnership to launch food-based programs in 2021. Programs launched this year included on-site food pantries at patient discharge and the Second Harvest one-call system. On-site pantries allow case management team members to work collaboratively with nurses to evaluate a patient's access to food upon discharge. Evaluations showing food need allow case managers to supply patients with a bag of food upon discharge. Patients may call Second Harvest for further support, bag refills, home delivery and more. **In 2021, 25 patients were served through the program.**

2022 Goals and Programs

1. The Springfield Leadership Council for Diversity and Inclusion will kick off its local strategic planning process in 2022. A prioritized goal of the strategic plan is to develop a plan for inclusive local hiring and career pathways by developing stronger youth and school partnerships and continuing education opportunities for associates.

2. For the last three years, Mercy Health has been working collaboratively in Clark County to create Start Strong Clark County, a Maternal Infant Vitality coalition that includes the new Mercy Health — Springfield OBGYN practice, Springfield Regional Medical Center Birthing Center, local physicians, OBGYNs and our local federally qualified health center, Rocking Horse. As we approach 2022, we will continue collaboration among providers, patients and community education, as well as improved access to social supports for the needs of our patients.

Toledo

With eight hospitals serving Lucas, Wood, Defiance, Huron and Seneca counties, Mercy Health Toledo has prioritized addressing healthy moms and babies, neighborhood improvement and community identified health needs in order to improve the health and well-being of the community.

Prioritized community health needs

1. Chronic disease/obesity
2. Adult and youth mental health
3. Adult and youth drugs and opiates
4. Maternal and infant health/infant mortality
5. Social determinants of health (including health care system and access)
6. Injury prevention
7. Youth bullying

Healthy Connections Help Me Grow (HMG) Program

HMG is a home-visiting program that helps parents support their child's growth and development and builds strong families. **Serving 220 Lucas County and 32 Wood County families in 2021,** the program utilizes home visitors to conduct developmental screenings to create individualized family service plans and make connections to community resources and services. The program is based on a national model that is designed to work with overburdened families who are at risk for adverse childhood experiences (ACEs), including child maltreatment.

Getting Health Zone (GHZ)

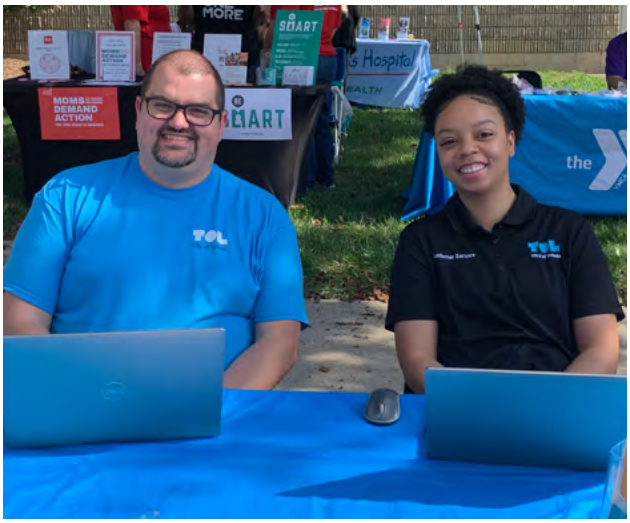
Located along the Cherry Street Corridor and the adjacent neighborhood, GHZ is a community-driven initiative working to increase infant vitality, improve the health and well-being of residents and create a thriving neighborhood where residents want to live, work and visit. Through an immersive community engagement process, residents with the support of almost 20 community partners developed four program goals:

1. Connect residents with information and resources to increase infant vitality/decrease infant mortality
2. Connect residents with living wage jobs and job training to assist them with credit repair and homeownership
3. Connect entrepreneurs with needed resources
4. Create a safe neighborhood park for residents

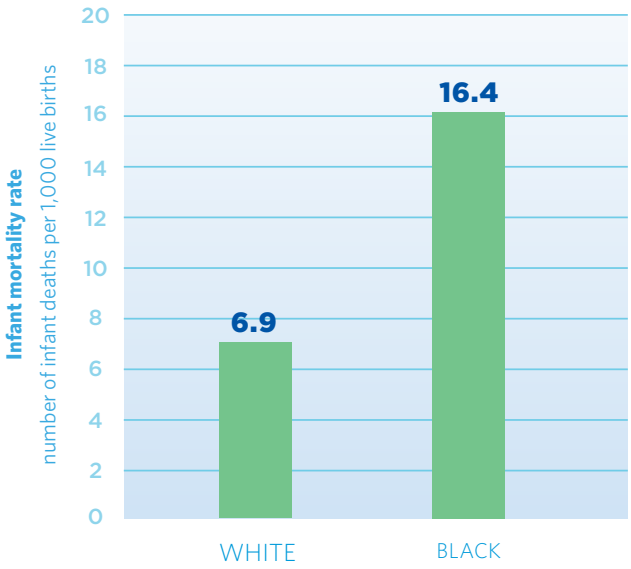
Over the last year, more than 1,000 residents have received free fresh produce, two job fairs were held in the community, five homes were renovated and sold to new homeowners, and more than 200 residents used services of the Financial Opportunity Center.

Reducing Infant Mortality

Zip codes 43608, 43610 and 43620 were among the five zip codes with the highest incidence of infant mortality in Lucas County. Premature birth and low birth weight are two of the most common factors of infant mortality in Lucas County. From 2018-2020, pre-term births decreased from 20.2% to 16.9% and low birth weight decreased from 22.2% to 13.7% in the three Mercy priority zip codes. In 2021 the infant mortality rate stabilized in the Cherry Legacy Getting Health Zone.



INFANT MORTALITY RATE, LUCAS COUNTY



In Lucas County, Black babies die at a rate 3x higher than White babies.

43608, 43610 and 43620 are among the top 5 highest zip codes for infant deaths.

Community Paramedicine Program

The Community Paramedicine Program aims to reduce avoidable emergency department (ED) utilization rates, increase primary care engagement, and improve population health engagement and care coordination interventions by 2022. During the first year of the program, 125 patients received assistance in managing chronic conditions, ED visits for those patients decreased 50%, with hospital admissions decreasing by 30%. In a target three-month period during the program's first year, 35 patients were monitored. In that time period, 911 calls from those 35 participants were reduced by 117 calls. The goal of the program is to ensure patients are able to manage their care independently and consistently.

Supporting Rural Communities

Willard Hospital has seen their health programs improve patient cholesterol, HDL, LDL, triglycerides, glucose and weight measurements. Tiffin has seen improvement in triglycerides, glucose, A1c and weight measurements.

2022 Goals and Projects

1. Peloton, Mercy Health and Wayman Palmer YMCA have partnered to further improve the health of residents along the Cherry Street Corridor and adjacent neighborhoods. Peloton will be investing in the Wayman Palmer YMCA to create a Peloton Room and support a Community Outreach Coordinator position to further the work of the Getting Health Zone program and improve overall community health.

2. Mercy Health will continue to prioritize addressing food insecurity in our communities. In 2022, Mercy Health Toledo and SSOE will partner to address food needs in East Toledo. We will also expand our Health Connections Baby Pathways program, a partnership with Produce Perks to offer produce prescriptions to expectant mothers. Funded through the Ohio Department of Health, Mercy will open 30 additional slots for the program in 2022, bringing total program participants to 75 expectant mothers.

3. Mercy Health Toledo will partner with Johnson & Johnson and the African American Male Wellness Walk organization to increase awareness of peripheral artery disease. Mercy physicians will engage patients and community members through educational events and screenings, leading up to the African American Male Wellness Walk to be held August 2022.

4. 2022 will see growth and expansion of our parish nursing program. Over the past year, COVID-19 has helped expand our partnerships and connections with many local churches. Mercy Health Toledo will continue those partnerships to address chronic disease, physical activity and overall well-being.

5. Associates from Mercy Health Tiffin and Willard will be trained in QPR (Question, Persuade, Refer), an evidence-based suicide prevention program that focuses on three steps. Once trained, associates will deliver the program to area businesses.

Youngstown

Our goal is to create a healthier community, one member at a time. Through community health programs and local partnerships, our trained staff offers free and reduced-cost health services in local neighborhoods that address needs as identified by the community.

Programs

Cancer prevention and detection

Community Health education

Diabetes education

Faith community nursing program

Fatherhood support

Hispanic Health Program

Joanie Abu Mobile Mammography Unit

Joanie's Promise

Joanie's Sisters

Kikel Mobile Dental Clinic

Lead poisoning prevention program

ManUp Mahoning Valley

Mercy Health Women's Care Center Centering Pregnancy

Neighborhood Health Watch

New Start Treatment Center

Peer recovery support services

Prescription assistance

Regional tobacco treatment

Resource Mothers program

St. Joe's at the Mall

Stepping Out program

Stroke survivor's support group

Trauma services at Mercy Health St. Elizabeth Youngstown Hospital

WIC (Women, Infants and Children)

Resource Mothers & Fatherhood Support Programs

Our mission is to strengthen families and prevent infant mortality. The Resource Mothers and Fatherhood programs provide one-on-one support to men and women in Mahoning & Trumbull counties. The program offers educational home visits, mentoring and support groups, Care Seat program, CPR training, cooking classes and connection to other social services as needed. **In 2021 more than 116 new and soon-to-be parents participated throughout 2021, including 27 fathers. More than 70 babies were born into the program.** Additionally, the Youngstown market had **199 participants in the Empowering Moms program and 109 in the Fresh Start program.**

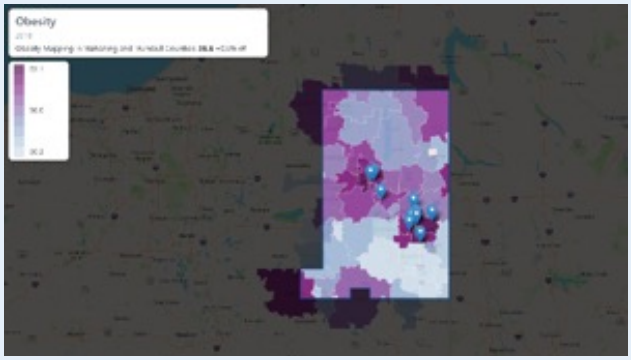
Hispanic Health

One of our continued goals is to support and help immigrant communities improve their health and well-being through targeted programs and access to care. Programs advocate, support and increase community of care for the Hispanic community.

Our bilingual staff helps connect patients to medical and social services, participate in health classes or screenings, make provider appointments and assist with interpretation during appointments. 2021 saw a demand for Hispanic health services increase, as patients and community members navigated COVID-19.

Stepping Out Program

Our Stepping Out program currently provides information, assessments and fitness activities to the community at 11 different sites as well as health fairs. In 2021, 34,075 individuals participated in Stepping Out events or activities, including aerobic/strength classes, line dancing, ballroom dancing, walking classes and yoga. Obesity continues to be an issue in Mahoning and Trumbull counties. To address this need, many Stepping Out programs are located in areas with the highest rates of obesity.



Obesity rates for Mahoning and Trumbull counties.

2022 Goals and Programs

1. Focus on facility expansion that will allow for co-location of clinical and community care and services including the Centering Pregnancy program, women's health and primary care.

2. Expand focus on infant mortality and disparities in infant deaths in the tri-county area (Columbiana, Mahoning and Trumbull counties).

FATHERHOOD SUPPORT PROGRAM: A TESTIMONIAL

As the Johnson family was expecting their first son, father-to-be Brandon was just out of school and working to make ends meet. Through the Mercy Health Fatherhood Support Program, funded in partnership with the Mercy Health Foundation Mahoning Valley, Brandon and family were connected to education sessions and resources to help them prepare for their new arrival. "At the time, there were a lot of things that were given to us that I probably would have struggled to have gotten. I was barely affording things, and the program actually helped a lot." Learning about communication with children, discipline, educational and developmental milestones, and health eating habits, Brandon shared, "I never thought about how important that was, so in general your child can have a happy home. I really appreciate everything the program has done."

Community Health Leadership

System Leadership

Dave Belde, PhD
Vice President, Community Health-Maryland, South Carolina, Virginia

Erin Hurlburt, MD
Chief Medical Officer, Population and Community Health

Shivonne Laird, PhD MPH
System Director, Community Health Impact

Kendra N. Smith, AICP MSUS
Vice President, Community Health-Ohio, Kentucky

Patrick Schmidt
Program Manager, Community Benefit & CHNA

Market Leadership

Leigh Ann Ballegeer
Director, Community Health
Paducah, Kentucky

Becky Clay Christensen
Executive Director, Community Health
Richmond, Virginia

Sean Dogan
Director, Community Health
Greenville, South Carolina

Leigh A. Greene, MSSA LSW CHW
Director, Community Health
Youngstown, Ohio

Gina Hemenway, MPPA
Executive Director, Community Health
Cincinnati, Ohio

George Kleb
Executive Director, Bon Secours Community Works
Baltimore, Maryland

Meghan Mills
Community Outreach Program Manager
Irvine, Kentucky

Jessica Henry Schultz, CPH
Director, Community Health
Toledo, Ohio

Brett Sierra, DHSc MPH
Director, Community Health
Hampton Roads, Virginia

Tyler Smith, MS CSCS
Director, Community Health
Lima, Ohio

Catherine Woskobnick
Director, Community Health
Lorain, Ohio

Carolyn Young, MAHCM
Director, Community Health
Springfield, Ohio

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